

Introduced by Senator LenoFebruary 26, 2015

An act to amend Section 1385.04 of, and to add Section 1385.045 to, the Health and Safety Code, and to amend Section 10181.4 of, and to add Section 10181.45 to, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 546, as introduced, Leno. Health care coverage: rate review.

Existing law, the federal Patient Protection and Affordable Care Act (PPACA), requires the United States Secretary of Health and Human Services to establish a process for the annual review of unreasonable increases in premiums for health insurance coverage in which health insurance issuers submit to the secretary and the relevant state a justification for an unreasonable premium increase prior to implementation of the increase. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan or health insurer in the individual, small group, or large group markets to file rate information with the Department of Managed Health Care or the Department of Insurance. For large group plan contracts and policies, existing law requires a plan or insurer to file rate information with the department at least 60 days prior to implementing an unreasonable rate increase, as defined in PPACA. Existing law requires the plan or insurer to also disclose specified aggregate data with that rate filing.

This bill would recast the rate information requirement to require large group health care service plans and health insurers to file with the department at least 60 days prior to implementing any rate change all required rate information for any product with a rate change if any of certain conditions apply. The bill would require the plan or insurer to file additional aggregate rate information with the department on or before October 1, 2016. The bill would also require that the plan or insurer disclose the aggregate data for all products sold in the large group market for all rate filings submitted under these provisions on an annual basis. The bill would require the respective departments to conduct a public meeting regarding large group rate changes. The bill would require these meetings to occur annually after the department has reviewed the large group rate information required to be submitted annually by the plan or insurer. The bill would authorize a health care service plan or health insurer that exclusively contracts with no more than 2 medical groups to provide or arrange for professional medical services for enrollees or insureds to meet this requirement by disclosing its actual trend experience for the prior year using benefit categories that are the same or similar to those used by other plans or health insurers.

Because a willful violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

The people of the State of California do enact as follows:

- 1 SECTION 1. Section 1385.04 of the Health and Safety Code
- 2 is amended to read:
- 3 1385.04. (a) For large group health care service plan contracts,
- 4 all health plans shall file with the department ~~at least 60 days prior~~
- 5 ~~to implementing any rate change~~ all required rate information ~~for~~
- 6 ~~unreasonable rate increases. This filing shall be concurrent with~~
- 7 ~~the written notice described in subdivision (a) of Section 1374.21.~~

1 *for rate changes aggregated for the entire large group market.*
2 *This information shall be submitted on or before October 1, 2016,*
3 *and on or before October 1, annually thereafter.*

4 (b) (1) For large group rate filings, health plans shall submit
5 all information that is required by PPACA. A plan shall also submit
6 any other information required pursuant to any regulation adopted
7 by the department to comply with this article.

8 (2) *For each health plan that offers coverage in the large group*
9 *market, the department shall conduct a public meeting regarding*
10 *large group rate changes. The meeting shall occur after the*
11 *department has reviewed the information required in (a), on or*
12 *before November 1, 2016, and on or before November 1, annually*
13 *thereafter.*

14 (c) A health care service plan subject to subdivision (a) shall
15 also disclose the following ~~aggregate data for all rate filings for~~
16 ~~the aggregate rate filing for the large group market~~ submitted
17 under this section in the large group health plan market:

18 (1) Number and percentage of rate filings reviewed by the
19 following:

20 (A) Plan year.

21 (B) Segment type.

22 (C) Product type.

23 (D) Number of subscribers.

24 (E) Number of covered lives affected.

25 ~~(2) The plan's average rate increase by the following categories:~~

26 ~~(A) Plan year.~~

27 ~~(B) Segment type.~~

28 ~~(C) Product type.~~

29 (2) *Any factors affecting the rate, and the actuarial basis for*
30 *those factors, including:*

31 (A) *Geographic region.*

32 (B) *Age, including age rating factors.*

33 (C) *Occupation.*

34 (D) *Industry.*

35 (E) *Health status, including health status factors considered.*

36 (F) *Employee, employee and dependents, including a description*
37 *of the family composition used.*

38 (G) *Enrollee share of premiums.*

39 (H) *Enrollee cost sharing.*

1 (I) Covered benefits in addition to basic health care services,
2 as defined in subdivision (b) of Section 1345, and other benefits
3 mandated under this article.

4 (J) Any other factors that affect the rate that are not otherwise
5 specified.

6 (3) (A) The plan's overall annual medical trend factor
7 assumptions in each rate filing for all benefits and by aggregate
8 benefit category, including hospital inpatient, hospital outpatient,
9 physician services, prescription drugs and other ancillary services,
10 laboratory, and radiology. A health plan that exclusively contracts
11 with no more than two medical groups in the state to provide or
12 arrange for professional medical services for the enrollees of the
13 plan shall instead disclose the amount of its actual trend experience
14 for the prior contract year by aggregate benefit category, using
15 benefit categories that are, to the maximum extent possible, the
16 same or similar to those used by other plans.

17 (B) The amount of the projected trend attributable to the use of
18 services, price inflation, or fees and risk for annual plan contract
19 trends by aggregate benefit category, such as hospital inpatient,
20 hospital outpatient, physician services, prescription drugs and
21 other ancillary services, laboratory, and radiology. A health plan
22 that exclusively contracts with no more than two medical groups
23 in the state to provide or arrange for professional medical services
24 for the enrollees of the plan shall instead disclose the amount of
25 its actual trend experience for the prior contract year by aggregate
26 benefit category, using benefit categories that are, to the maximum
27 extent possible, the same or similar to those used by other plans.

28 (C) A comparison of claims cost and rate of changes over time.

29 (D) Any changes in enrollee cost sharing over the prior year
30 associated with the submitted rate filing.

31 (E) Any changes in enrollee benefits over the prior year
32 associated with the submitted rate filing.

33 ~~(3)~~

34 (F) Any cost containment and quality improvement efforts since
35 the plan's last rate filing for the same category of health benefit
36 plan. To the extent possible, the plan shall describe any significant
37 new health care cost containment and quality improvement efforts
38 and provide an estimate of potential savings together with an
39 estimated cost or savings for the projection period.

(d) The department may require all health care service plans to submit all rate filings to the National Association of Insurance Commissioners' System for Electronic Rate and Form Filing (SERFF). Submission of the required rate filings to SERFF shall be deemed to be filing with the department for purposes of compliance with this section.

SEC. 2. Section 1385.045 is added to the Health and Safety Code, to read:

1385.045. (a) (1) For large group health care service plan contracts, all health plans shall file with the department at least 60 days prior to implementing any rate change all required rate information for any product with a rate change if any of the following apply:

(A) The rate change is equal to or greater than the average rate increase for individual market products approved by the California Health Benefits Exchange.

(B) The rate change is equal to or greater than the average rate increase approved by the CalPERS board for the subsequent calendar year.

(C) The rate change would cause the large group purchaser to incur the excise tax.

(D) At the request of the large group purchaser.

(2) This filing shall be concurrent with the written notice described in subdivision (a) of Section 1374.21, except for a filing at the request of the large group purchaser. A filing at the request of a large group purchaser may occur at any time after receipt of the written notice and prior to the rate taking effect.

(b) A plan shall disclose to the department all of the following for each large group rate filing described in (a):

(1) Company name of plan and contact information.

(2) Number of plan contract forms covered by the filing.

(3) Plan contract form numbers covered by the filing.

(4) Product type, such as a preferred provider organization or health maintenance organization.

(5) Segment type.

(6) Type of plan involved, such as for profit or not for profit.

(7) Whether the products are opened or closed.

(8) Enrollment in each plan contract and rating form.

(9) Enrollee months in each plan contract form.

- 1 (c) Any factors affecting the rate, and the actuarial basis for the
2 factor, including but not limited to:
- 3 (1) Geographic region.
 - 4 (2) Age, including age rating factors.
 - 5 (3) Occupation.
 - 6 (4) Industry.
 - 7 (5) Health status, including health status factors considered.
 - 8 (6) Employee, employee and dependents, including a description
9 of the family composition used.
 - 10 (7) Enrollee share of premiums.
 - 11 (8) Enrollee cost sharing.
 - 12 (9) Covered benefits in addition to basic health care services,
13 as defined in subdivision (b) of Section 1345, and other benefits
14 mandated under this article.
 - 15 (10) Any other factor that affects the rate that is not otherwise
16 specified.
- 17 (d) The plan shall also disclose the following:
- 18 (1) Annual rate.
 - 19 (2) Total earned premiums in each plan contract form.
 - 20 (3) Total incurred claims in each plan contract form.
 - 21 (4) Average rate increase initially requested.
 - 22 (5) Review category: initial filing for new product, filing for
23 existing product, or resubmission.
 - 24 (6) Average rate of increase.
 - 25 (7) Effective date of rate increase.
 - 26 (8) Number of subscribers or enrollees affected by each plan
27 contract form.
 - 28 (9) The plan's overall annual medical trend factor assumptions
29 in each rate filing for all benefits and by aggregate benefit category,
30 including hospital inpatient, hospital outpatient, physician services,
31 prescription drugs and other ancillary services, laboratory, and
32 radiology. A health plan that exclusively contracts with no more
33 than two medical groups in the state to provide or arrange for
34 professional medical services for the enrollees of the plan shall
35 instead disclose the amount of its actual trend experience for the
36 prior contract year by aggregate benefit category, using benefit
37 categories that are, to the maximum extent possible, the same or
38 similar to those used by other plans.
 - 39 (10) The amount of the projected trend attributable to the use
40 of services, price inflation, or fees and risk for annual plan contract

trends by aggregate benefit category, such as hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology. A health plan that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the enrollees of the plan shall instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories that are, to the maximum extent possible, the same or similar to those used by other plans.

(11) A comparison of claims cost and rate of changes over time.

(12) Any changes in enrollee cost sharing over the prior year associated with the submitted rate filing.

(13) Any changes in enrollee benefits over the prior year associated with the submitted rate filing.

(14) The certification described in subdivision (b) of Section 1385.06.

(15) Any changes in administrative costs.

(16) Any other information required for rate review under PPACA.

(17) Any cost containment and quality improvement efforts since the plan's last rate filing for the same category of health care service plan. To the extent possible, the plan shall describe any significant new health care cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period.

(e) For rate filings subject to this section, the director shall make a decision to modify or deny a rate change that is unreasonable, inadequate, or otherwise in violation of this article or federal law prior to the implementation of the rate change by the plan.

(f) The department may require all health care service plans to submit all rate filings to the National Association of Insurance Commissioners' System for Electronic Rate and Form Filing (SERFF). Submission of the required rate filings to SERFF shall be deemed to be filing with the department for purposes of compliance with this section.

(g) A plan shall submit any other information required under PPACA. A plan shall also submit any other information required pursuant to any regulation adopted by the department to comply with this article.

SEC. 3. Section 10181.4 of the Insurance Code is amended to read:

10181.4. (a) For large group health insurance policies, all health insurers shall file with the department ~~at least 60 days prior to implementing any rate change~~ all required rate information for ~~unreasonable rate increases. This filing shall be concurrent with the written notice described in Section 10199.1.~~ *rate changes aggregated for the entire large group market. This information shall be submitted on or before October 1, 2016, and on or before October 1, annually thereafter.*

(b) (1) For large group rate filings, health insurers shall submit all information that is required by PPACA. A health insurer shall also submit any other information required pursuant to any regulation adopted by the department to comply with this article.

(2) *For each health insurer that offers coverage in the large group market, the department shall conduct a public meeting regarding large group rate changes. The meeting shall occur after the department has reviewed the information required in (a), on or before November 1, 2016, and on or before November 1, annually thereafter.*

(c) A health insurer subject to subdivision (a) shall also disclose the following ~~aggregate data for all rate filings for the aggregate rate filing for the large group market~~ submitted under this section in the large group health insurance market:

(1) Number and percentage of rate filings reviewed by the following:

(A) Plan year.

(B) Segment type.

(C) Product type.

(D) Number of insureds.

(E) Number of covered lives affected.

~~(2) The insurer's average rate increase by the following categories:~~

~~(A) Plan year.~~

~~(B) Segment type.~~

~~(C) Product type.~~

(2) *Any factors affecting the rate, and the actuarial basis for those factors, including:*

(A) *Geographic region.*

(B) *Age, including age rating factor.*

1 (C) *Occupation.*

2 (D) *Industry.*

3 (E) *Health status, including health status factors considered.*

4 (F) *Employee, employee and dependents, including a description*
5 *of the family composition used.*

6 (G) *Insured share of premiums.*

7 (H) *Insured cost sharing.*

8 (I) *Covered benefits in addition to basic health care services,*
9 *as defined in subdivision (b) of Section 1345 of the Health and*
10 *Safety Code, and other benefits mandated under this article.*

11 (J) *Any other factors that affect the rate that are not otherwise*
12 *specified.*

13 (3) (A) *The health insurer's overall annual medical trend factor*
14 *assumptions in each rate filing for all benefits and by aggregate*
15 *benefit category, including hospital inpatient, hospital outpatient,*
16 *physician services, prescription drugs and other ancillary services,*
17 *laboratory, and radiology. A health insurer that exclusively*
18 *contracts with no more than two medical groups in the state to*
19 *provide or arrange for professional medical services for the*
20 *insureds of the health insurer shall instead disclose the amount of*
21 *its actual trend experience for the prior contract year by aggregate*
22 *benefit category, using benefit categories that are, to the maximum*
23 *extent possible, the same or similar to those used by other health*
24 *insurers.*

25 (B) *The amount of the projected trend attributable to the use of*
26 *services, price inflation, or fees and risk for annual health insurer*
27 *contract trends by aggregate benefit category, such as hospital*
28 *inpatient, hospital outpatient, physician services, prescription*
29 *drugs and other ancillary services, laboratory, and radiology. A*
30 *health insurer that exclusively contracts with no more than two*
31 *medical groups in the state to provide or arrange for professional*
32 *medical services for the insureds of the health insurer shall instead*
33 *disclose the amount of its actual trend experience for the prior*
34 *contract year by aggregate benefit category, using benefit*
35 *categories that are, to the maximum extent possible, the same or*
36 *similar to those used by other health insurers.*

37 (C) *A comparison of claims cost and rate of changes over time.*

38 (D) *Any changes in insured cost sharing over the prior year*
39 *associated with the submitted rate filing.*

1 (E) Any changes in insured benefits over the prior year
2 associated with the submitted rate filing.

3 ~~(3)~~

4 (F) Any cost containment and quality improvement efforts since
5 the health insurer's last rate filing for the same category of health
6 insurance policy. To the extent possible, the health insurer shall
7 describe any significant new health care cost containment and
8 quality improvement efforts and provide an estimate of potential
9 savings together with an estimated cost or savings for the projection
10 period.

11 (d) The department may require all health insurers to submit all
12 rate filings to the National Association of Insurance
13 Commissioners' System for Electronic Rate and Form Filing
14 (SERFF). Submission of the required rate filings to SERFF shall
15 be deemed to be filing with the department for purposes of
16 compliance with this section.

17 SEC. 4. Section 10181.45 is added to the Insurance Code, to
18 read:

19 10181.45. (a) (1) For large group health insurance policies,
20 all health insurers shall file with the department at least 60 days
21 prior to implementing any rate change all required rate information
22 for any product with a rate change if any of the following apply:

23 (A) The rate change is equal to or greater than the average rate
24 increase for individual market products approved by the California
25 Health Benefits Exchange.

26 (B) The rate change is equal to or greater than the average rate
27 increase approved by the CalPERS board for the subsequent
28 calendar year.

29 (C) The rate change would cause the large group purchaser to
30 incur the excise tax.

31 (D) At the request of the large group purchaser.

32 (2) This filing shall be concurrent with the written notice
33 described in subdivision (a) of Section 10199.1, except for a filing
34 at the request of the large group purchaser. A filing at the request
35 of a large group purchaser may occur at any time after receipt of
36 the written notice and prior to the rate taking effect.

37 (b) A health insurer shall disclose to the department all of the
38 following for each large group rate filing described in (a):

39 (1) Company name of the health insurer and contact information.

40 (2) Number of health insurance policies covered by the filing.

- 1 (3) Health insurance policy form numbers covered by the filing.
- 2 (4) Product type, such as a preferred provider organization or
- 3 health maintenance organization.
- 4 (5) Segment type.
- 5 (6) Type of health insurer involved, such as for profit or not for
- 6 profit.
- 7 (7) Whether the products are opened or closed.
- 8 (8) Enrollment in each health insurance policy and rating form.
- 9 (9) Insured months in each health insurance policy form.
- 10 (c) Any factors affecting the rate, and the actuarial basis for the
- 11 factor, including but not limited to:
 - 12 (1) Geographic region.
 - 13 (2) Age, including age rating factors.
 - 14 (3) Occupation.
 - 15 (4) Industry.
 - 16 (5) Health status, including health status factors considered.
 - 17 (6) Employee, employee and dependents, including a description
 - 18 of the family composition used.
 - 19 (7) Insured share of premiums.
 - 20 (8) Insured cost sharing.
 - 21 (9) Covered benefits in addition to basic health care services,
 - 22 as defined in subdivision (b) of Section 1345, and other benefits
 - 23 mandated under this article.
 - 24 (10) Any other factor that affects the rate that is not otherwise
 - 25 specified.
- 26 (d) The health insurer shall also disclose the following:
 - 27 (1) Annual rate.
 - 28 (2) Total earned premiums in each health insurance policy form.
 - 29 (3) Total incurred claims in each health insurance policy form.
 - 30 (4) Average rate increase initially requested.
 - 31 (5) Review category: initial filing for new product, filing for
 - 32 existing product, or resubmission.
 - 33 (6) Average rate of increase.
 - 34 (7) Effective date of rate increase.
 - 35 (8) Number of insureds affected by each health insurance policy
 - 36 form.
 - 37 (9) The health insurer's overall annual medical trend factor
 - 38 assumptions in each rate filing for all benefits and by aggregate
 - 39 benefit category, including hospital inpatient, hospital outpatient,
 - 40 physician services, prescription drugs and other ancillary services,

laboratory, and radiology. A health insurer that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the insureds of the health insurer shall instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories that are, to the maximum extent possible, the same or similar to those used by other health insurers.

(10) The amount of the projected trend attributable to the use of services, price inflation, or fees and risk for annual health insurance policy trends by aggregate benefit category, such as hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology. A health insurer that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the insureds of the health insurer shall instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories that are, to the maximum extent possible, the same or similar to those used by other health insurers.

(11) A comparison of claims cost and rate of changes over time.

(12) Any changes in insured cost sharing over the prior year associated with the submitted rate filing.

(13) Any changes in insured benefits over the prior year associated with the submitted rate filing.

(14) The certification described in subdivision (b) of Section 10181.6.

(15) Any changes in administrative costs.

(16) Any other information required for rate review under PPACA.

(17) Any cost containment and quality improvement efforts since the health insurer's last rate filing for the same category of health insurance policy. To the extent possible, the health insurer shall describe any significant new health care cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period.

(e) For rate filings subject to this section, the commissioner shall make a decision to modify or deny a rate change that is unreasonable, inadequate, or otherwise in violation of this article

1 or federal law prior to the implementation of the rate change by
2 the health insurer.

3 (f) The department may require all health insurers to submit all
4 rate filings to the National Association of Insurance
5 Commissioners' System for Electronic Rate and Form Filing
6 (SERFF). Submission of the required rate filings to SERFF shall
7 be deemed to be filing with the department for purposes of
8 compliance with this section.

9 (g) A health insurer shall submit any other information required
10 under PPACA. A health insurer shall also submit any other
11 information required pursuant to any regulation adopted by the
12 department to comply with this article.

13 SEC. 5. No reimbursement is required by this act pursuant to
14 Section 6 of Article XIII B of the California Constitution because
15 the only costs that may be incurred by a local agency or school
16 district will be incurred because this act creates a new crime or
17 infraction, eliminates a crime or infraction, or changes the penalty
18 for a crime or infraction, within the meaning of Section 17556 of
19 the Government Code, or changes the definition of a crime within
20 the meaning of Section 6 of Article XIII B of the California
21 Constitution.